HIPAA Privacy Policy Patient Consent Form

At SKP Massage LLC, we are committed to protecting the privacy and security of your health information in accordance with HIPAA and applicable federal and state laws.

You have the right to:

- Receive a copy of this Notice of Privacy Practices
- Request restrictions on certain uses or disclosures of your information
- Request confidential communications
- Access and obtain a copy of your records
- Request corrections to your health information
- Receive a list of disclosures of your information
- File a complaint if you believe your privacy rights have been violated

With your consent, we may use or share your health information to:

- Provide treatment and care
- Coordinate with other healthcare providers
- Process billing and payment
- Operate and improve our business
- Comply with legal and regulatory requirements

We may also disclose information without your consent when permitted or required by law, including:

- Medical emergencies
- Public health reporting
- Court orders or legal proceedings
- Audits and evaluations
- Reporting abuse, neglect, or threats of violence

By signing below, I acknowledge that:

- I have received or been offered a copy of the SKP Massage LLC Notice of Privacy Practices.
- I understand my rights regarding my protected health information.
- I authorize SKP Massage LLC to use and disclose my health information for treatment, payment, and healthcare operations as permitted by law.
- I understand that I may revoke this consent in writing at any time, except to the extent action has already been taken.

Client Printed Name: _____ **Client Signature:** _____ **Date:** _____

Parent/Guardian Printed Name: _____ **Relationship to Client:** _____

Parent/Guardian Signature: _____ **Date:** _____

This notice remains in effect until replaced or revised in writing. Effective Date: January 1, 2026